EXHIBIT 4

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL INDUSTRY	MDL NO. 1456
AVERAGE WHOLESALE PRICE LITIGATION	Civil Action:
	01-CV-12257-PBS
THIS DOCUMENT RELATES TO U.S.	Judge Patti B. Saris
Ex rel. Ven-A-Care of the Florida	Magistrate Judge
Keys, No. 06-CV-11337-PBS	Marianne B. Blower

/

The Videotaped Deposition of SANDRA KRAMER,

Taken at 2860 Eyde Parkway,

East Lansing, Michigan,

Commencing at 9:08 a.m.,

Tuesday, March 25, 2008,

Before Cynthia A. Chyla, CSR 0092.

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Q. And what was your Bachelor's in?
A. Also in education and dental hygiene.
Q. When did you first begin working for Michigan Medicaid?
A. In 1974.
Q. Was that your first job out of college?
A. No.
Q. Okay. Was that your first job in the healthcare field?
A. No.
Q. Okay. Describe the other jobs that you had in the healthcare field before starting with Michigan Medicaid in 1974?
A. I was a dental hygienist.
Q. Any other positions in the healthcare field?
A. In high school I was a dental assistant.
Q. Okay. We don't have to go all the way back to high school.
A. Okay.
Q. Any others?
A. Not that I -- I don't recall anything else.
Q. Okay. And, so, you began working for

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Michigan Medicaid in 1974. How long did you work for Michigan Medicaid?
A. I worked for Michigan Medicaid to approximately 2000.
Q. Did you hold the same position from 1974 to 2000?
A. No, I did not.
Q. Okay. What was your first position?
A. I was a dental health consultant.
Q. Okay. And what was your second position?
A. I was a policy analyst.
Q. When did you take the position as a policy analyst?
A. I believe it was around 1978.
Q. Could you briefly describe the job responsibilities of a policy analysis -- or a policy analyst? I'm sorry.
A. Develop policy, analyze regulations, implement policies, evaluate the policies.
Q. And was one of the policies that you were responsible for the drug payment policies to providers who were administering under Michigan Medicaid?

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A. Yes.
Q. Were you responsible for that beginning in 1978?
A. There probably was a short period that I was not. I don't exactly remember when I started doing pharmacy policy.
Q. So at least by sometime in the early 1980s you were in charge of that area?
MR. HENDERSON: Objection.
A. Probably even into 1979.
BY MR. GABEL:
Q. Okay. And were you responsible for drug payments to providers, at least the policy area, from '79 through the time you left in 2000?
A. Could you define --
MR. HENDERSON: Objection.
A. -- responsible?
BY MR. GABEL:
Q. I guess better to ask you: What was your involvement in -- in the drug payment policies to providers under -- who were administering under Michigan Medicaid?

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A. I would at management's direction research reimbursement technology -- or research reimbursement techniques and make recommendations.
Q. And were you responsible for that from the entire period of sometime in the late '70s-early '80s until you left in 2000?
A. Yes.
Q. Were you responsible for drafting the portion of the state plan that dealt with drug payments to providers?
MR. HENDERSON: Objection.
MR. MATUS: I'm objecting to your question. You're using the term responsible; I think it's vague. It's not clear whether this is one of her responsibilities, or if you are trying to assert that she is principally the principal person responsible for --
BY MR. GABEL:
Q. Were you the principal person responsible?
A. I am also confused by that, because it makes like -- I feel like it's coming across that that's the only thing I did.

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Q. No, no, I certainly -- no. I want to focus on that because that is most relevant for our purposes of this litigation, at least in my mind, and I know you had other areas of responsibility, but in that particular area, drug payments to providers under Michigan Medicaid, were you the primary person responsible for that topic?
A. I still need further clarification on it, the term responsible. Because I mentioned to you before that I would make recommendations for the management team and then it would be their approval, and then I would act upon what they would approve. So it wasn't that I was the sole person; it was more as much as a state government could be more of a collaboration.
Q. Okay. Were you the individual at Michigan Medicaid who was most -- focused most of your time on that topic area?
MR. HENDERSON: Objection.
A. Again, that's unclear, because any other task would be somewhat related to reimbursement, but would not totally be reimbursement issues.

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BY MR. GABEL:
Q. Okay. Did you draft the state plan language that dealt with drug reimbursement to providers?
A. We --
MR. HENDERSON: Objection.
A. That's confusing to me, because --
BY MR. GABEL:
Q. Did you draft portions of the state plan?
MR. HENDERSON: Objection; form.
A. I would -- I had drafted state plan language before.
BY MR. GABEL:
Q. And which portions of the state plan had you drafted previously?
MR. HENDERSON: Objection to the form.
A. I would need --
MR. GABEL: I'm sorry, what's the objection?
MR. HENDERSON: As I understand it, there probably way back when there was a state plan, probably in the early stages of the Medicaid program, long before Ms. Kramer started to work there, and there have been amendments over time. So your reference to the state plan is vague and ambiguous.
MR. GABEL: Okay.
MR. HENDERSON: Also lacks specificity.
BY MR. GABEL:
Q. Did you help draft amendments to the state plan?
A. Yes.
Q. And which amendments to the state plan had you drafted?
A. They have various numbers related to the state plan, and I would have to look at the state plan to determine the sections. I don't recall the numbers.
Q. Did you draft any state plan amendments dealing with drug payments to providers?
A. Yes.
Q. From the period of 1978 through 2000, was there anyone else aside from you that you're aware of who drafted state plan amendments relating to drug payments to providers?

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A. I'm uncertain.
Q. Were you the primary person responsible for drafting those state plan amendments?
MR. HENDERSON: Objection.
A. I would think so, but I'm uncertain.
BY MR. GABEL:
Q. Have you ever worked for a pharmacy?
A. No.
Q. Have you ever worked for a drug manufacturer?
A. I already addressed that question.
Q. In any role aside from a consultant. Have you ever been an employee of a drug manufacturer?
A. No.
Q. Okay. Never worked for a wholesaler?
A. No.
Q. Am I right that you held the position of a policy analyst from 1978 straight to 2000?
A. Those sound -- yes, those sound like the right dates.
Q. Okay. Did you work in any particular division of Michigan Medicaid as a policy analyst?

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cost."
Do you see that?
A. Um-hmm. Yes.
Q. What did you mean when you stated average wholesale prices are generally inflated significantly over pharmacy purchase costs?
MR. HENDERSON: Objection.
A. It was my understanding that for generic drugs that the state would have to set maximum allowable cost rates to represent pharmacy costs.
BY MR. GABEL:
Q. And did you understand that AWPs did not reflect pharmacy costs?
A. I understood that they were frequently not updated, and, yes, we would have to set maximum allowable costs.
Q. And, in fact, you stated they were inflated significantly over pharmacy purchase costs; right?
A. That's what it says, yes.
Q. Is there anything that you see in this affidavit today that you believe was inaccurate now?
MR. MATUS: She hasn't had a chance

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to read the whole thing. Are you asking her to verify every word of this as accurate?
MR. GABEL: Yes.
BY MR. GABEL:
Q. Is there anything that you believe is inaccurate about this document?
MR. MATUS: If you need to look at it, Sandy, go ahead.
A. I think, you know, in the section -- in point 9 are generally inflated significantly, and looking back on it now my interpretation of significant, you know, is that 25 percent, you know, 50 percent, you know, or is that 1000 percent. I think at the time I was thinking that it was greater than the 13 percent, 13.5 and the 15.1 that I was conveying in point 8 related to the brand name drugs.
BY MR. GABEL:
Q. Okay. And that's something I'd like to discuss.
Did you understand that the difference -- well, let's back up.
The difference between what a

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pharmacy purchased a drug for and AWP, do you understand that to be termed as the spread sometimes?
A. I didn't at the time that this was written or at the time when I was working for the Michigan Medicaid program.
Q. All right. Do you now understand that --
A. Yeah.
Q. -- that sometimes is referred to as the spread?
A. Yes.
Q. Can I refer to that in the deposition today and you'll know what I'm talking about?
A. Yes.
Q. Okay. Did you understand that the spread for generics was larger than the spread for brand name drugs?
A. Yes.
Q. Okay. What was that understanding based upon?
A. Probably at the time that I was at Michigan Medicaid, input from the pharmacists.
Q. So you would discuss AWP with pharmacists?

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A. Actually, I -- my responsibility included, as we mentioned before, setting the MACs.
Q. Um-hmm.
A. The state MACs. And as part of that I was chair of what we called the Pharmacy Reimbursement Advisory Committee, or they call it PRAC -- P-R-A-C -- for short.
Q. Were pharmacists on PRAC?
A. Yes. So I would have gotten that information from them --
Q. Okay.
A. -- is my best recollection of it.
Q. And what was the source of information for your statement that AWPs are generally inflated significantly over pharmacy purchase costs?
A. As I mentioned, setting the maximum allowable cost prices and comparing those to the AWP that was -- I guess we're using the term significant spread. And that's why I would have felt comfortable putting that statement.
Q. Now, this Affidavit was dated sometime in 2001. But am I right to say that you understood that

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A. At the time that this was written who was he?
Q. Yes.
A. I'm uncertain. He probably was a bureau director at the time.
Q. Was he --
A. Management to me.
Q. So someone you reported to?
A. Probably not directly.
Q. But he was higher on the Michigan Medicaid hierarchy?
A. Yes.
Q. And in your memos to Mr. Smith or others higher on the Michigan Medicaid hierarchy, did you attempt to be as accurate as possible?
A. I would try to.
Q. You see the subject of this is elimination of actual acquisition costs reimbursement.
Do you see that?
A. Yes.
Q. What does that refer to?
A. I think it would refer to switching the

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reimbursement technique from AAC to EAC.
Q. And that switch was actually made in 1995; right?
A. Yes.
Q. So this is approximately three years before the switch was made?
A. Yes.
Q. Do you know why this was being discussed in 1992?
A. It explains here that the pharmacy association's newsletter published that there was going to be a change from AAC reimbursement for Michigan Medicaid.
Q. And it's dated -- it actually states that Mr. Smith agreed to move way from actual acquisition costs; is that right?
A. Yeah.
Q. Did you have a discussion with him regarding whether he did, in fact, agree to move away from AAC?
A. I don't recall.
Q. Did you ever have any discussions with Mr. Smith about moving away from AAC to EAC?

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A. Yes.
Q. Okay. How many -- how many times did you have discussions with him about that topic?
A. I don't know how many times.
Q. Do you recall ever discussing with him what AWPs were meant to represent?
A. Not really. Not -- no.
Q. You state, and I'd like to focus here on the second paragraph, the last sentence of that paragraph, it states: "If such a proposal were adopted, there could be tremendous cost implications for the program."
What did you mean by that?
A. I meant that AWP minus 10 percent is -- would not have been what we were paying under AAC reimbursement.
Q. So fair to say that you thought there would have to be a steeper discount off of AWP if you were going to approximate AAC?
A. Yes.
Q. And when you say tremendous cost implications, what did you mean by that phrase?
MR. HENDERSON: Objection.

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A. I guess I was trying to get his attention.
BY MR. GABEL:
Q. Did you get his attention?
A. I don't remember him responding.
Q. Okay. The next paragraph you say: "As an example, I have attached the direct (or acquisition cost) and AWP for several new products from a major generic company. The price differentials are enormous with AWP ranging from 13 percent to 500 percent above acquisition cost!!!"
With the three exclamations, were you also trying to get his attention?
MR. HENDERSON: Objection.
A. I think it speaks for itself.
BY MR. GABEL:
Q. Okay. Fair enough.
You state: "The price differentials are enormous --" well, actually, strike that.
It's fair to say that as early as 1992 you realized that in some instances AWPs were upwards of 500 percent above acquisition costs?
A. For the generic.

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Q. For the generic specifically?
A. That's what I'm referring to here.
Q. Okay. And this is what you were conveying to Mr. Smith in 1992?
A. Right. In looking at this documentation when I pulled it together here, too, I noted that the attachment just refers to the differential between AWP and -- or the spread I guess is the term we're using, direct price, and direct price is not necessarily what the pharmacist would have been paying.
Q. Did you understand that the pharmacist could be paying even less than direct price?
A. At the time it may not have been my understanding, but looking back at this documentation, the direct price I know was not necessarily what the pharmacist was paying.
Q. They could have been paying lower than direct price?
A. Yes.
Q. Okay. And let's look at this document that you attach.
Well, first, let me make sure. Is

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this the document that you attached to the memo to Mr. Smith?
A. I'm thinking it is. I'm uncertain --
Q. They were produced to us back to back, so that's why I was putting them together.
A. Right. I notice a lot of my documents got shuffled.
Q. Okay.
A. So ....
Q. Do you have any reason to believe that this is not the document that you would have been forwarding along to him?
A. I think it is. It's date stamped the 13th and this was written November 30th.
Q. Okay. Thanks.
And you said it's date stamped November 13th. That's 1992; right?
A. Correct.
Q. Okay. And this is from Geneva Pharmaceuticals?
A. Yes.
Q. And did this come directly to you, or did

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you receive this from some other source?
A. I don't recall exactly. I assume if it was in my possession, it came directly to me.
Q. Directly to you from Geneva?
A. Yeah. Dear sir or Madam.
Q. Okay. Did you ever have any discussions with Mr. Ron Hartmann, the author of this?
A. I believe I have.
Q. Okay. Did you discuss in particular how AWP compared to acquisition costs?
A. No.
Q. What were your discussions with Mr. Hartmann about?
A. I don't recall exactly what form, but I believe he attended meetings, public meetings that were held by the MSA.
Q. And you see in this letter from Mr. Hartmann, it lists AWP in one column and direct prices in another column. And, in fact, there -- there are spreads between those two prices; correct? And in one instances -- in one instance you note that the spread is approximately 500 percent; right?

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A. (Nods head.)
Q. Is that referring to the last drug on this list?
A. I would have to do the math again.
Q. But overall, you see there --
A. It seems to be the biggest spread.
Q. Okay. Now, in your experience as a policy analyst for Michigan Medicaid, would you, when looking at spreads, be more concerned about the percentage differential or the dollar differential? For instance, there's a 500 percent spread on that final drug, but it's less than a $20 spread when it's expressed in dollars.
For the top drug, we see that there's about $100 spread. Would you be more concerned about the dollar issue or the percentage issue?
MR. HENDERSON: Objection to the form.
A. I would be concerned about the percentage.
BY MR. GABEL:
Q. Percentage. Okay.
Although even with a lower

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A. Yes.
Q. All right. And, so, in that case there would be a different discount below AWP that the small volume provider would have in comparison to the large volume provider?
A. Some of that, though, would be dependent on the actual purchase size that was associated with the NDC.
Q. Okay. But there could be a variety of percentages depending on what type of discounts providers could take advantage of?
A. I wasn't privy to how steep those discounts were or what the range --
Q. You didn't believe that all providers got the same exact discount when they purchased drugs? Providers purchased drugs for a variety of different prices; right?
MR. HENDERSON: Objection to the form.
A. I -- you know, no, I didn't believe that they all purchased for the same price.
BY MR. GABEL:

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Q. So, when you're attempting to establish an estimated acquisition cost and you use a particular percentage, whether it's 13.5 for independent pharmacies or some other percentage for chain pharmacies, you recognize that in certain instances providers will receive drug payments that are higher than their actual acquisition cost; right?
MR. HENDERSON: Objection to the form.
A. It's difficult for me to respond to your questions because the MSA set different price screens depending on which type of drug you were referring to. So, when you're --
BY MR. GABEL:
Q. If the screen didn't come into play?
A. When you're referring to EAC and -- you know, so, it would be helpful if you could say for brand name drugs and nonbrand drugs or generic drugs.
Q. For generic drugs, assuming the screens did not come into play, assuming it wasn't going to reach the MAC, did you understand that certain providers would be paid greater than their acquisition costs when

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Michigan used an EAC system?
A. Yeah.
Q. Did you believe that the providers receiving those payments that were greater than their acquisition costs were submitting false claims to Michigan Medicaid?
MR. HENDERSON: Objection.
MR. MATUS: Objection. Calls for a legal conclusion.
A. I -- I didn't monitor those kinds of issues.
BY MR. GABEL:
Q. Did you believe they were committing fraud?
MR. HENDERSON: Objection.
MR. MATUS: Same objection; calls for a legal conclusion.
A. That was outside of my responsibilities.
BY MR. GABEL:
Q. Did you personally believe, or considering it now, did you believe that that was wrong for the providers?
MR. MATUS: Objection; vague.
A. That wasn't my responsibility.

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BY MR. GABEL:
Q. Did you ever have any discussions with anyone on whether that would be wrong for providers to receive payments above their actual acquisition costs?
A. I don't recall that.
Q. You've already mentioned that you understood that the spread for generics would generally be greater than the spread for brands; correct?
A. Yes.
Q. Were there any other classes of drugs that you understood the spread would be greater than other classes of drugs for?
MR. HENDERSON: Objection to the form.
A. Not that I recall.
BY MR. GABEL:
Q. Have any drug manufacturers communicated to you that the AWPs published in the compendia reflected actual acquisition costs to providers?
A. I don't recall that.
Q. When drug manufacturers would communicate to you and send you the AWPs, did they ever tell you that

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BY MR. GABEL:
Q. This AWP screen, whether it was AWP, AWP minus 8 percent, AWP minus 10 percent, that would only act as a cap if actual acquisition costs exceeded that amount; right?
A. Correct.
Q. Okay. So, AWP would only come into play to lower Michigan Medicaid's payments in the event actual acquisition costs or usual and customary costs exceeded that AWP screen?
A. Where I'm having the problem is the actual acquisition costs. It's really the provider's charge representing the actual acquisition costs. If that exceeded the AWP, then they would be cut back on the brand name drugs and drugs that didn't have a MAC on it.
Q. Okay. For generic drugs that did have MACs, AWP wouldn't come into play whatsoever with respect to how the provider would be reimbursed for those drugs prior to 1995?
A. If the AWP discount was lower than the MAC, it would come into play.

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Q. Okay. So the MAC wouldn't only act as a screen, the AWP would be an additional screen potentially?
A. Yes.
MR. GABEL: I think we're about to run out of time on the tape. Why don't we just break now, get a quick lunch. Can we do a quick lunch, is that all right?
MR. MATUS: Yeah, that's fine.
MR. GABEL: Why don't we go off the record and we'll discuss.
THE VIDEOGRAPHER: Going off the record at 11:51 and 51 seconds a.m.
(Lunch recess was taken from 11:51 a.m. to 12:35 p.m.)
THE VIDEOGRAPHER: We're back on the record at 12:35 and 15 seconds p.m.
BY MR. GABEL:
Q. Ms. Kramer, how were MACs set when you worked for Michigan Medicaid?
MR. HENDERSON: Objection.
A. Can you define a time period?

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BY MR. GABEL:
Q. Were you responsible -- let me ask a different question.
Were you responsible for setting MACs?
A. For a lot of the time that I was in the policy area.
Q. For what time period were you responsible?
A. I don't remember the exact dates.
Q. Were you responsible from 1990 through the time you left for setting state MACs?
A. Yes.
Q. Okay. How were those set during that time period?
A. During that time period, the best that I can recall is that we had a pharmacist consultant with the department. I don't remember how frequently he came in, but periodically he would come in and I would provide him with utilization data on the generic drugs and he would do research of maybe what other states or another insurer would have priced MAC at, and then also he would have availability of wholesaler information

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and would establish target MACs, and then I would take those target MACs and publish them in drafts for comment with the pharmacist and other people that were interested in pharmacy issues.
Q. And then after the comments came in?
A. After the comments came in, those were resolved and the prices were published with a 30-day lead time.
Q. When you published the target MACs for comment, did you ever receive any comments from manufacturers on the MACs?
A. I don't recall whether there was or not.
Q. Who was the pharmacist consultant that you used to set MACs in the '90s?
A. Robert Phetteplace, P-H-E-T-T-E-P-L-A-C-E.
Q. And did this -- you stated this pharmacist consultant had access to wholesale prices?
A. He was a practicing pharmacist.
Q. So he knew what his actual acquisition costs would be for particular drugs?
A. I assume so. He never showed me the, you know, his invoices or anything, but ....

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commercial carriers had this approach to implementing EAC, so as we -- basically I was researching the data, I was looking to them for their lead and what they had done customarily and, you know, discuss this with the Michigan Pharmacists Association, ran various simulation studies, and eventually the option that was approved is the one that you see on this page.

Q. Did you believe that pharmacies with a larger number of stores could obtain drugs at cheaper prices than those with just a few stores?

A. The data showed the differential here based on our actual acquisition cost payments -- or I shouldn't say that. Based on payments made during our actual acquisition cost policy.

Q. And those studies indicated that there would be a difference on what providers --

A. There was one.

Q. There was one.

A. Yeah.

Q. Okay. Now, under the section that is entitled MACs -- do you see that?

A. Yes.

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Q. It says: "When actual acquisition costs are lower than the AWP minus discount and the MAC, payment will increase with EAC."

A. Um-hmm.

Q. What did you understand that to mean?

MR. HENDERSON: Sorry, what page are you on?

MR. GABEL: First page, there's a -- it's Cost Analysis For Budget Neutrality, MACs.

BY MR. GABEL:

Q. And -- let me restate the question. In that sentence: "When actual acquisition costs are lower than the AWP minus discount and the MAC, payment will increase with EAC."

Why did you understand that payments would increase?

A. This has been a really long time since 1995, and I'm uncertain how the computer system was actually set up in these kind of instances. Because here it says regardless of what NDC and what the AWP was that they would guarantee the MAC, and I'm uncertain how the computer system was actually set up.

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Q. Aside from --

A. This really isn't the policy nor is it the logic in the computer, it's just a summary.

Q. Setting aside the logistics of how the computer system would do it, did you understand that with an EAC-based payment system -- or, I'm sorry, an EAC system that used AWP minus some discount that if a provider were able to acquire drugs for lower than that AWP minus the discount amount and that drug didn't hit the MAC level that the provider's payment would be higher than it was under the actual acquisition cost system? Am I saying that right?

MR. HENDERSON: Objection to the form.

A. To look at the bulletin that's the actual policy and what was published was that product costs will be paid based on the lowest of, you know, and then it lists, one, two, three. So, if the AWP discounted was lower than the MAC, then the AWP discounted would be paid.

BY MR. GABEL:

Q. Um-hmm. And if the actual acquisition

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costs, in fact, were lower than the AWP minus discount, then the provider would get some sort of margin on their drug; is that right?

A. Right.

MR. HENDERSON: Objection.

A. Right.

BY MR. GABEL:

Q. And that was inequitable if you're going to use a standardized system?

A. Right. But the problem is -- or the point I'd like to make is that because we spent so much time comparing the payment data under the old system to the, you know, transitioning to EAC, there was that comfort level that because we were using the 13.5 and the 15.1, that those were representative of what those -- the product costs would be.

Q. Okay. But we've looked at other documents where you saw that spreads varied from 13 percent to 500 percent, and that was for generics?

A. That was for generics, not for brand drugs.

Q. Did you understand that there was some consistent percentage for brand drugs on what the